Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THE VAZ CLINIC, PA

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-11-3984-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JULY 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Each time when we sent OV notes to Texas Mutual we printed the original OV notes instead of notes with changes that reflect two more diagnosis, (401.1) and (722.4) We can not appeal one more time because we passed 90 day filing deadline."

Amount in Dispute: $125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position the E&M note of 3.16.11 does not reflect complexity associated with code 99214."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2011	CPT Code 99214 Office Visit	$125.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - CAC-150-Payer deems the information submitted does not support this level of service.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (May be comprised of either the remittance advice remarked code or NCPDP reject reason code.)
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.

- 890-Denied per AMA CPT code description for level of service and/or nature or presenting problems.
- 892-Denied in accordance with DWC rules and/or medical fee guideline.
- 878-Appeal (Request for Reconsideration) previously processed. Refer to rule 133.250(H).
- CAC-18-Duplicate claim/service.

Issues

Does the documentation support billing CPT code 99214 on the disputed date of service? Is the requestor entitled to reimbursement?

Findings

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

A review of the submitted March 16, 2011 report does not document at least two of the three key components required for CPT code 99214; therefore, the respondent's denial of reimbursement is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/15/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.